

Acute Periodontal Conditions Answer Sheet

Name: _____ Rank/Grade: _____

Duty Location: _____ DSN: _____

Your Mailing Address: _____

Provide your answers below:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Please read the following, sign, and date:

I affirm that these answers are the result of my work alone and that I have not received assistance from others.

(Signature)

(Date)

Mail ONLY THIS SHEET or fax it to DIS at:

USAF Dental Investigation Service
Detachment 1, USAFSAM
310C B Street, Bldg 1H
Great Lakes, IL 60088

Fax number: DSN 792-7667 or commercial (847) 688-7667